TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Center

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-1074-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am filing this dispute on the above patient, because Gallagher Bassett has denied our CPT 99214 two times. This level of service was selected by the Physician because of the complexity of this visit at least 2 of the 3 components were met. This patient had multiple injuries and x-ray that had to be addressed separately. He also had to refer the patient to another provider and review those notes as well to discuss the treatment plan with the patient after his visit."

Amount in Dispute: $216.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on December 20, 2016. Texas Administrative Code §133.307 (d) (1) states,

> Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
>
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As no response was received, this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2016	99214	$216.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 (150) – Payer deems the information submitted does not support this level of service
   - BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments
   - W3 – Request for reconsideration
   - P1 (P12) Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the carrier's denial supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed service 99214 with claim adjustment reason code 150 – "Payer deems the information submitted does not support this level of service." 28 Texas Administrative Code §134.203(b) states in pertinent part,

> For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
>
> (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

The submitted code in dispute has a narrative description of 99214 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

Review of the submitted document dated July 18, 2016 finds:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Detailed History	History of present illness – (3) conditions Review of systems – Extended Past medical, family, social history – N/A Score – Expanded Problem Focused	No
Detailed Examination	Body areas – Each Extremity (4) Score – Expanded Problem Focused	No

Medical decision making of moderate complexity	Number of Diagnoses or Treatment Options – (3) Elemental Level: Multiple Amount and /or Complexity of Data Reviewed – Minimal Level of Decision Making – Low Complexity	No
Usually, the presenting problem(s) are of moderate to high severity	Risk of Significant Complications, Morbidity, and / or Mortality Level of Decision Making: Low Complexity	No
Typically, 25 minutes are spent face-to-face with the patient and/or family	No documentation of time	No

The requestor stated, "He also had to refer to another provider and review those notes…" Review of the submitted document found the statement, "3VLwrist – normal" and "skin not broken so no need for immun. or lab work." Therefore, this referral and or time spent with the patient is not supported.

Based on the above, the carrier's denial is supported.

2. Pursuant to the above, no additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		April 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.